Plan Year 2016

C and O Employees' Hospital Association Medicare Part D Prescription Drug Plan

Prior Authorization (PA) Criteria

Prior Authorization: C and O Employees' Hospital Association Medicare Part D Prescription Drug Plan requires you (or your physician) to get prior authorization for certain drugs. This means that you will need to get approval from C and O Employees' Hospital Association Medicare Part D Prescription Drug Plan before you fill your prescriptions. If you don't get approval, C and O Employees' Hospital Association Medicare Part D Prescription Drug Plan may not cover the drug.

PLEASE READ:
THIS DOCUMENT CONTAINS INFORMATION ABOUT OUR PRIOR AUTHORIZATION CRITERIA.

The COEHA has a contract with the Federal Government to provide our members with an enhanced Medicare Part D Prescription Drug Plan. Enrollment in C and O Employees' Hospital Association Medicare Part D Prescription Drug Plan depends upon contract renewal.

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Last updated 7/01/2016 Version: 11

C and O Employees' Hospital Association Medicare Part D Prescription Drug Plan

Prior Authorization Criteria
Last Updated 7/1/2016

Products Affected

- ABILIFY MAINTENA INJ 300MG, 400MG (New Starts Only)
- ARIPIPRAZOLE 10MG ODT (New Starts Only)
- ARIPIPRAZOLE 15MG ODT (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Patient has tried and failed or was intolerant to 1 of the following: olanzapine, quetiapine, risperidone or ziprasidone. If prescribed for schizoaffective disorder, member does not require trial of previous agent.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- *adapalene cream 0.1%*
- ATRALIN GEL 0.05%
- *avita gel 0.025%*
- DIFFERIN CREAM 0.1%
- DIFFERIN GEL 0.3%
- EPIDUO 0.3-2.5% GEL
- RETIN-A CREAM 0.025%, 0.05%, 0.1%
- RETIN-A MICRO GEL 0.04%, 0.1%
- TRETIN-X CREAM 0.0375%
- *tretinoin cream 0.025%, 0.05%, 0.1%*
- *tretinoin microsphere gel 0.04%, 0.1%*
- *adapalene gel 0.1%, 0.3%*
- *avita cream 0.025%*
- AZELEX CREAM 20%
- DIFFERIN GEL 0.1%
- DIFFERIN LOTION 0.1%
- EPIDUO GEL 0.1-2.5%
- RETIN-A GEL 0.025%, 0.01%
- RETIN-A MICRO GEL PUMP 0.08%
- *tretinoin 0.05% gel*
- *tretinoin gel 0.025%, 0.01%*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	All FDA-approved indications not otherwise excluded from Part D.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- ACTEMRA INJ 162MG/0.9ML
- ACTEMRA IV INJ 200MG/10ML

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Patient has tried or was intolerant to Enbrel AND Humira
Age Restrictions	
Prescriber Restriction	Prescribed by a Rheumatology Specialist or in consultation with a Rheumatology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– ADAGEN INJ 250UNIT

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– ADCIRCA TAB 20MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Primary Pulmonary Arterial Hypertension or Secondary Pulmonary Arterial Hypertension.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– ADEMPAS TAB 0.5MG, 1MG, 1.5MG, 2MG, 2.5MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restriction	Restricted to or in consult with Pulmonologist or Cardiologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	For diagnosis of Pulmonary Arterial Hypertension, trial of one (1) of the following: Letairis, Opsumit or Tracleer. For diagnosis of Persistent/recurrent Chronic Thromboembolic Pulmonary Hypertension (CTEPH) (WHO Group 4), trial of prior therapy is not required.

Products Affected

- AFINITOR DISPERZ TAB 2MG, 3MG, 5MG (New Starts Only)
- AFINITOR TAB 2.5MG, 5MG, 7.5MG, 10MG (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For the treatment of progressive neuroendocrine tumors of pancreatic origin in patients with unresectable, locally advanced, or metastatic disease. For the treatment of patients with advanced renal cell carcinoma after failure of treatment with Sutent or Nexavar. For the treatment of patients with subependymal giant cell astrocytoma associated with tuberous sclerosis who require therapeutic intervention but are not candidates for curative surgical resection.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– ALECENSA 150MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by an Oncology Specialist or in consultation with an Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– AMITIZA CAP 8MCG, 24MCG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Patient has tried and failed Miralax (glycolax).
Age Restrictions	Age 18 and above.
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– AMPYRA TAB 10MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Restricted to or in consult with Neurology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- ANDROID CAP 10MG
- FORTESTA GEL 2%
- *methyltestosterone 10mg cap*
- TESTOSTERONE GEL 1%
- TESTOSTERONE GEL 50MG
- TESTRED CAP 10MG
- VOGELXO GEL PUMP 1%
- AXIRON SOLN 30MG/ACT
- METHITEST TAB 10MG
- TESTIM GEL 1%
- TESTOSTERONE GEL 2%
- TESTOSTERONE GEL PUMP 1%
- VOGELXO GEL PACKET 1%

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Two morning testosterone levels fall below the normal range for a healthy adult male. Patient must have tried and failed ANDRODERM and ANDROGEL. For Android, Methitest, and Testred, if prescribed for delay in sexual development or metastasis from malignant tumor of breast, inoperable metastatic disease (skeletal) in women 1 to 5 years postmenopausal, testosterone levels and previous trial of ANDRODERM and ANDROGEL not required.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- ANDRODERM PATCH 2MG
- ANDRODERM PATCH 4MG
- ANDROGEL 1% (25MG)
- ANDROGEL 1% (50MG)
- ANDROGEL 1.62% (1.25GM)
- ANDROGEL 1.62% (2.5GM)
- ANDROGEL PUMP 1.62%

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Two morning testoterone levels fall below the normal range for a healthy adult male.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– APTIOM TAB 200MG, 400MG, 600MG, 800MG (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– ARCALYST INJ 220MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Restricted to Rheumatology Specialists or in consult with Rheumatology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- ARIXTRA INJ 2.5MG/0.5ML
- *fondaparinux inj 2.5mg/0.5ml*
- ARIXTRA INJ 5MG/0.4ML, 7.5MG/0.6ML, 10MG/0.8ML
- *fondaparinux inj 5mg/0.4ml, 7.5mg/0.6ml, 10mg/0.8ml*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Body weight less than 50 kg (venous thromboembolism prophylaxis only)
Required Medical Info	Patient has history of Heparin Induced Throbmocytopenia (HIT) or HIT is medically suspected. Or, prescribed for prevention or treatment of DVT in an orthopedic surgery patient.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- FANAPT TAB 1MG, 2MG, 4MG, 6MG, 8MG, 10MG, 12MG (New Start
- FANAPT TAB TITRATION PACK (New Starts Only)
- INVEGA 273MG/0.875ML SYR (New Starts Only)
- INVEGA 410MG/1.315ML SYR (New Starts Only)
- INVEGA 546MG/1.75ML SYR (New Starts Only)
- INVEGA 819MG/2.625ML SYR (New Starts Only)
- INVEGA SUSTENNA INJ 39MG, 78MG, 117MG, 156MG, 234MG (Nev
- INVEGA TAB 1.5MG, 3MG, 6MG, 9MG (New Starts Only)
- LATUDA TAB 20MG, 40MG, 60MG, 80MG, 120MG (New Starts Only)
- *paliperidone 1.5mg er tab (New Starts Only)*
- *paliperidone 3mg er tab (New Starts Only)*
- *paliperidone 6mg er tab (New Starts Only)*
- *paliperidone 9mg er tab (New Starts Only)*
- SAPHRIS SL TAB 2.5MG, 5MG, 10MG (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Patient has tried and failed or was intolerant to 1 of the following: aripiprazole, olanzapine, quetiapine, risperidone or ziprasidone. If prescribed for schizoaffective disorder, member does not require trial of previous agent.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– AUBAGIO TAB 7MG, 14MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For use in Multiple Sclerosis (MS), patient has a relapsing form of MS.
Age Restrictions	
Prescriber Restriction	Prescribed by a neurologist or an MS specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	For use in MS, patient has a relapsing form of MS and patient has tried interferon beta-1a intramuscular (Avonex), interferon beta-1a subcutaneous (Rebif), interferon beta-1b (Betaseron or Extavia), or glatiramer acetate (Copaxone) AND dimethyl fumarate (Tecfidera). Exceptions to having tried an interferon beta-1a or -1b product (Avonex, Betaseron, Extavia, or Rebif) or glatiramer acetate (Copaxone) can be made if the patient is unable to administer injections due to dexterity issues or visual impairment. Patients who have tried natalizumab (Tysabri) for MS and have a relapsing form of MS will receive authorization, they are not required to try an interferon beta product or glatiramer acetate.

Products Affected

- BUTISOL TAB 30MG, 50MG (New Starts Only)
- *phenobarbital tab 15mg, 16.2mg, 30mg, 32.4mg, 60mg, 64.8mg, 97.2mg, 1*
- SECONAL CAP 100MG (New Starts Only)
- *phenobarbital elixir 20mg/5ml (New Starts Only)*
- *phenobarbital tab 15mg, 16.2mg, 30mg, 32.4mg, 60mg, 64.8mg, 97.2mg, 1*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	Prior Authorization required for members 65 years and older.
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– BELEODAQ IV INJ 500MG (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or in consult with Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- BIVIGAM INJ 10GM/100ML
- FLEBOGAMMA 10% INJ
- GAMMAGARD INJ 2.5GM/25ML
- GAMMAPLEX INJ 10GM/200ML
- OCTAGAM INJ 2GM/20ML, 25GM, 500ML
- CARIMUNE INJ 6GM
- GAMASTAN S/D INJ
- GAMMAKED 1GM/10ML INJ
- GAMUNEX-C INJ 1GM/10ML
- PRIVIGEN INJ 20GM/200ML

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– BOSULIF TAB 100MG, 500MG (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or in consult with Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– CAPRELSA TAB 100MG, 300MG (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by an Oncologist or Endocrinologist or under the direct consultation of an Oncologist or Endocrinologist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– CAYSTON INHALATION SOLN 75MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Restricted to or in consult with Infectious Disease or Pulmonology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Approval will be based off BvD coverage determination.

Products Affected

– CERVARIX INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	PA not required for members age 9-25 years.
Prescriber Restriction	
Coverage Duration	Approved for duration of plan year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- CHOLBAM 250MG CAP
- CHOLBAM 50MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a hepatologist or pediatric gastroenterologist.
Coverage Duration	Initial will be 3 months, then if criteria is met approved for the rest of the plan year.
Other Criteria	Renewal requires documentation of stable or improved liver function.

Products Affected

- CIMZIA INJ 200MG/ML

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For moderate to severe RA requires intolerance to or failure of therapy with methotrexate (greater than 20mg/wk) AND etanercept (Enbrel) AND adalimumab (Humira). For Crohn's disease requires a trial of adalimumab (Humira)
Age Restrictions	
Prescriber Restriction	For RA must be prescribed by Rheumatology Specialist. For Crohn's Disease must be prescribed by Gastroenterology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	For members with a diagnosis of early, severe-onset RA additional required medical information is not required.

Products Affected

- BERINERT INJ 500UNIT
- CINRYZE INJ 500UNIT
- FIRAZYR INJ 30MG/3ML

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– COMETRIQ CAP PACK (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or in consult with Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- CORLANOR 5MG TAB
- CORLANOR 7.5MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	The patient is on a maximally tolerated dose of beta blocker or has a history of a documented intolerance, contraindication, or a hypersensitivity to beta blocker.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a Cardiology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- COSENTYX 150MG/ML AUTO-INJECTOR
- COSENTYX 150MG/ML SYR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Intolerance to or failure of therapy with Humira
Age Restrictions	
Prescriber Restriction	Psoriatic Arthritis and Ankylosing Spondylitis: Prescriber must be a Rheumatologist. Plaque Psoriasis: Prescriber must be a Dermatologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– COTELLIC 20MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by an Oncology Specialist or in consultation with an Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- CYRAMZA 100MG/10ML INJ (New Starts Only)
- CYRAMZA 500MG/50ML INJ (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by an Oncology Specialist or in consultation with an Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– CYSTARAN OPHTH SOLN 0.44%

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For the treatment of corneal cystine crystal accumulation in patients with cystinosis
Age Restrictions	
Prescriber Restriction	Prescribed by or in consultation with an Ophthalmologist or Geneticist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– DARZALEX 100MG/5ML INJ (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by an Oncology Specialist or in consultation with an Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– MARINOL CAP 2.5MG, 5MG, 10MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis of loss of appetite due to AIDS OR chemotherapy induced nausea and vomiting
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Products Affected

– DYMISTA INHALER 137-50MCG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded by Part D.
Exclusion Criteria	
Required Medical Info	Requires trial of 2 formulary alternatives
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- EMPLICITI 300MG INJ (New Starts Only)
- EMPLICITI 400MG INJ (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by an Oncology Specialist or Hematology Specialist, or in consultation with an Oncology Specialist or Hematology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- ENBREL INJ 25MG, 50MG
- ENBREL SURECLICK INJ 50MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For moderate to severe RA or Psoriatic Arthritis requires Trial of or failure of therapy with methotrexate (greater than 20mg/wk). Plaque Psoriasis: Trial of, or intolerance to, methotrexate at a dose of 15mg/week or trial of, or intolerance to, soriatane.
Age Restrictions	
Prescriber Restriction	Rheumatoid Arthritis, Psoriatic Arthritis and Ankylosing Spondylitis: Prescriber must be a Rheumatologist. All Plaque Psoriasis: Prescriber must be a Dermatologist.
Coverage Duration	Approved for the duration of contract year subject to formulary change and member eligibility.
Other Criteria	For members with a diagnosis of early, severe-onset RA, additional required medical information is not required.

Products Affected

– ERIVEDGE CAP 150MG (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Restricted to or in consult with Oncology Specialist.
Coverage Duration	Covered for duration of plan year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– ERWINAZE INJ 10000UNIT (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Restricted to Oncology Specialists or in consult with Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– FARYDAK CAP 10MG, 15MG, 20MG (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by an Oncology or Hematology Specialist or in consultation with an Oncology or Hematology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- FERRIPROX 100MG/ML SOLN
- FERRIPROX TAB 500MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Restricted to Hematology Specialists or in consult with Hematology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- FIRMAGON INJ 120MG (New Starts Only)
- FIRMAGON INJ 80MG (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or in consultation with Oncologist or Urologist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Approval subject to BvD determination

Products Affected

– FLECTOR PATCH 1.3%

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility
Other Criteria	

Products Affected

– FOLOTYN INJ 40MG/2ML (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or on consultation with Hematologist or Oncologist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Approval subject to BvD determination.

Products Affected

– FORTEO SOLN 600MCG/2.4ML

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member has had at least 1 fracture, OR member has BMD screening results of -2.5 or below, OR member has previously used and failed a bisphosphonate.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– FYCOMPA TAB 2MG, 4MG, 6MG, 8MG, 10MG, 12MG (New Starts On

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– GARDASIL INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	PA not required for members age 9-26.
Prescriber Restriction	
Coverage Duration	Approved for duration of plan year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– GATTEX INJ 5MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis of short bowel syndrome with less than 200cm of remnant functional intestine. Dependent on parenteral support for at least 12 months and at least 3 days per week.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– GILENYA TAB 0.5MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For use in Multiple Sclerosis (MS), patient has a relapsing form of MS.
Age Restrictions	
Prescriber Restriction	Prescribed by a neurologist or an MS specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	For use in MS, patient has a relapsing form of MS and patient has tried interferon beta-1a intramuscular (Avonex), interferon beta-1a subcutaneous (Rebif), interferon beta-1b (Betaseron or Extavia), or glatiramer acetate (Copaxone) AND dimethyl fumarate (Tecfidera). Exceptions to having tried an interferon beta-1a or -1b product (Avonex, Betaseron, Extavia, or Rebif) or glatiramer acetate (Copaxone) can be made if the patient is unable to administer injections due to dexterity issues or visual impairment. Patients who have tried natalizumab (Tysabri) for MS and have a relapsing form of MS will receive authorization, they are not required to try an interferon beta product or glatiramer acetate.

Products Affected

– GILOTRIF TAB 20MG, 30MG, 40MG (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or in consultation with an Oncology Specialist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- GLEEVEC TAB 100MG, 400MG (New Starts Only)
- *imatinib 100mg tab (New Starts Only)*
- *imatinib 400mg tab (New Starts Only)*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by Oncologist or Hematologist, or under the direct consultation with an Oncologist or Hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- NORDITROPIN FLEXPRO INJ 5MG/1.5ML, 10MG/1.5ML, 15MG/1.5M
- NORDITROPIN NORDIFLEX PEN 30MG/3ML

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	The criteria for approval of growth hormones in adults require the diagnosis of Somatropin Deficiency Syndrome (defined by failure to stimulate Growth Hormone secretion (peak GH level of 10mcg/L or less) by one of the acceptable provocative tests). This may include adults who as children had Growth Hormone deficiency or adults with known pituitary disease.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– HARVONI TAB 90-400MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	1) Patient is diagnosed with chronic HCV (greater than 6 months) with genotype indicated 2) Current HCV-RNA titer 3) Documentation that member does or does not have cirrhosis 4) Previous Hepatitis C Treatments
Age Restrictions	Member must be 18 years of age or older
Prescriber Restriction	Prescribed by, or in consultation with, a Gastroenterologist, Hepatologist, Infectious Disease or Transplant Specialist
Coverage Duration	Coverage duration of 12–24 weeks based on cirrhosis status and previous treatment.
Other Criteria	1) Treatment-naïve without cirrhosis-approval for 12 weeks (patients with HCV RNA less than 6M IU/mL may be treated by physician for 8-week course if appropriate). 2)Treatment-naïve with compensated cirrhosis: approval for 12 weeks. 3) Treatment-experienced without cirrhosis: approval for 12 weeks. 4) Treatment-experienced with compensated cirrhosis: approval for 24 weeks (patients using in combination with ribavirin may be treated by physician with 12-week course if appropriate).

Products Affected

– HETLIOZ CAP 20MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Patient is totally blind.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- *amitriptyline tab 10mg, 25mg, 50mg, 75mg, 100mg, 150mg (New Starts O*
- *benztropine tab 0.5mg, 1mg, 2mg*
- *clomipramine cap 25mg, 50mg, 75mg (New Starts Only)*
- DEMEROL TAB 100MG
- *dipyridamole tab 25mg, 50mg, 75mg*
- *doxepin cap 10mg, 25mg, 50mg, 75mg, 100mg, 150mg (New Starts Only)*
- *doxepin conc 10mg/ml (New Starts Only)*
- FURADANTIN SUSP 25MG/5ML
- *glyburide micronized tab 1.5mg, 3mg, 6mg*
- *glyburide/metformin tab 1.25-250mg, 2.5-500mg, 5-500mg*
- *guanfacine ER tab 1mg, 2mg, 3mg, 4mg*
- *imipramine pamoate 75mg, 100mg, 125mg, 150mg (New Starts Only)*
- INDOCIN SUSP 25MG/5ML
- *indomethacin ER cap 75mg*
- *ketorolac inj 15mg/ml, 30mg/ml*
- MEGACE ES SUSP 625MG/5ML
- *megestrol acetate 125mg/ml susp*
- *megestrol acetate tab 20mg, 40mg (New Starts Only)*
- MEPERIDINE SOLN 50MG/5ML
- *meperitab tab 50mg*
- *methyldopa tab 250mg*
- *methyldopa/hydrochlorothiazide tab 250-15mg, 250-25mg*
- *nitrofurantoin susp 25mg/5ml*
- NORPACE CR CAP 100MG, 150MG
- PERSANTINE TAB 25MG, 50MG, 75MG
- RESERPINE TAB 0.25MG
- SURMONTIL CAP 25MG, 50MG, 100MG (New Starts Only)
- *thioridazine tab 10mg, 25mg, 50mg, 100mg (New Starts Only)*
- TIGAN CAP 300MG
- ANAFRANIL CAP 25MG, 50MG, 75MG (New Starts Only)
- CHLORPROPAMIDE TAB 100MG, 250MG
- DEMEROL INJ 50MG/ML
- DEMEROL TAB 50MG
- *disopyramide cap 100mg, 150mg*
- *doxepin cap 10mg, 25mg, 50mg, 75mg, 100mg, 150mg (New Starts Only)*
- ELAVIL 25MG TAB (New Starts Only)
- GLUCOVANCE TAB 2.5-500MG, 5-500MG
- *glyburide tab 1.25mg, 2.5mg, 5mg*
- GLYNASE MICRONIZED TAB 1.5MG, 3MG, 6MG
- *guanfacine IR tab 1mg, 2mg*
- *imipramine tab 10mg, 25mg, 50mg (New Starts Only)*
- *indomethacin cap 25mg, 50mg*
- INTUNIV 1MG, 2MG, 3MG, 4MG
- *ketorolac tab 10mg*
- MEGACE ORAL SUSP 40MG/ML (New Starts Only)
- *megestrol acetate susp 40mg/ml (New Starts Only)*
- *meperidine inj 25mg/ml, 50mg/ml, 100mg/ml*
- *meperitab tab 100mg*
- *meprobamate tab 200mg, 400mg*
- *methyldopa tab 500mg*
- *nifedipine cap 10mg, 20mg*
- NORPACE CAP 100MG, 150MG
- *pentazocine/naloxone tab 50-0.5mg*
- PROCARDIA CAP 10MG
- SURMONTIL CAP 25MG, 50MG, 100MG (New Starts Only)
- TENEX TAB 1MG, 2MG
- TIGAN 100MG/ML INJ
- TOFRANIL TAB 10MG, 25MG, 50MG (New Starts Only)

- *trihexyphenidyl soln 0.4mg/ml*
- *trimethobenzamide cap 300mg*
- *trimipramine 25 mg cap (New Starts Only)*
- *trihexyphenidyl tab 2mg, 5mg*
- *trimipramine 100 mg cap (New Starts Only)*
- *trimipramine 50 mg cap (New Starts Only)*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	No Prior Authorization required for members less than 65 years.
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	If for pain (NSAID), trial or intolerance to ONE of the following: other NSAIDs such as ibuprofen, tramadol, hydrocodone/acetaminophen, oxycodone/acetaminophen. If for pain (opioid), trial or intolerance to ONE of the following: NSAIDs such as ibuprofen, tramadol, hydrocodone/acetaminophen, acetaminophen with codeine. If for ADHD, trial or intolerance to ONE of the following: stimulant. If for anxiety, trial or intolerance to ONE of the following: buspirone, SSRIs, SNRIs, bupropion. If for arrhythmia, trial or intolerance to ONE of the following: Beta-blockers, Calcium channel blockers, flecainide. If for depression, trial or intolerance to ONE of the following: Secondary Amine TCAs (nortriptyline, protriptyline, desipramine, amoxapine), SSRIs, SNRIs, bupropion. If for diabetes (sulfonylurea), trial or intolerance to ONE of the following: glipizide or glimepiride. If for emesis, trial or intolerance to ONE of the following: ondansetron. If for hypertension, trial or intolerance to ONE of the following: ACE inhibitors, ARBs, Beta-blockers, Calcium channel blockers, Thiazide diuretics. If for palliative treatment of advanced carcinoma of the breast or endometrium, anorexia, cachexia, or an unexplained, significant weight loss in patients with a diagnosis of acquired immunodeficiency syndrome, trial of another product is not required but provider is notified of the high risk medication. If for Parkinson's, trial or intolerance to ONE of the following: Carbidopa/levodopa, pramipexole, ropinirole, bromocriptine, amantadine, selegiline. If for schizophrenia or psychosis, trial or intolerance to ONE of the following: Atypical antipsychotics: risperidone, olanzapine, ziprasidone, quetiapine. If for nifedipine IR, trial or intolerance to ONE of the following: amlodipine, felodipine, isradipine, nicardipine, nisoldipine, extended release nifedipine. If for stroke prevention, trial or intolerance to ONE of the following: clopidogrel, Aggrenox. If for Urinary Tract Infection (acute treatment), trial or intolerance to ONE of the following: ciprofloxacin, trimethoprim/sulfamethoxazole (TMP/SMX), amoxicillin/clavulanate, cefdinir. If for Urinary Tract Infection (prevention of recurrent), trial or intolerance to ONE of the following: trimethoprim/sulfamethoxazole (TMP/SMX), Methenamine hippurate.

Products Affected

- ACTIVELLA TAB 0.5-0.1MG, 1-0.5MG
- ANGELIQ TAB 0.25-0.5MG, 0.5-1MG
- *carbinoxamine tab 4mg*
- *carisoprodol/aspirin tab 200-325mg*
- *chlordiazepoxide/amitriptyline tab 5-12.5mg, 10-25mg (New Starts Only)*
- *clemastine tab 2.68mg*
- CLIMARA PRO PATCH 0.045-0.015MG
- *cyclobenzaprine tab 5mg, 7.5mg, 10mg*
- *cyproheptadine tab 4mg*
- *digoxin oral soln 0.05mg/ml*
- *diphenhydramine elixir 12.5mg/5ml (Rx only)*
- ERGOLOID MESYLATE TAB 1MG
- *estradiol tab 0.5mg, 1mg, 2mg*
- *estradiol weekly patch 0.025mg, 0.0375mg, 0.05mg, 0.06mg, 0.075mg, 0.1*
- *estropipate tab 0.75mg, 1.5mg, 3mg*
- EVAMIST SPRAY 1.53MG/SPRAY
- FEXMID TAB 7.5MG
- *fyavolv 1mg-5mcg tab*
- *hydroxyzine inj 25mg/ml, 50mg/ml*
- *hydroxyzine pamoate cap 25mg, 50mg, 100mg*
- *hydroxyzine tab 10mg, 25mg, 50mg*
- LANOXIN INJ 0.25MG/ML
- *lopreeza tab 0.5-0.1mg, 1-0.5mg*
- MENOSTAR PATCH 14MCG
- METAXALONE TAB 400MG
- *methocarbamol tab 500mg, 750mg*
- *mimvey tab 1-0.5mg*
- *norethindrone acetate/ethinyl estradiol tab 0.5mg-2.5mcg, 1mg-5mcg*
- *orphenadrine ER tab 100mg*
- ALORA PATCH 0.025MG, 0.05MG, 0.075MG, 0.1MG
- *carbinoxamine soln 4mg/5ml*
- *carisoprodol tab 350mg*
- *carisoprodol/aspirin/codeine tab 200-325-16mg*
- *chlorzoxazone tab 500mg*
- CLIMARA PATCH 0.025MG, 0.0375MG, 0.05MG, 0.06MG, 0.075MG, (
- COMBIPATCH 0.05-0.14MG, 0.05-0.25MG
- *cyproheptadine syrup 2mg/5ml*
- *digoxin inj 0.25mg/ml*
- *digoxin tab 0.25mg*
- ENJUVIA TAB 0.3MG, 0.45MG, 0.9MG, 1.25MG
- ESTRACE TAB 0.5MG, 1MG, 2MG
- *estradiol twice weekly patch 0.025mg, 0.0375mg, 0.05mg, 0.075mg, 0.1mg*
- *estradiol/norethindrone tab 0.5-0.1mg, 1-0.5mg*
- *estropipate tab 0.75mg, 1.5mg, 3mg*
- FEMHRT LOW DOSE TAB 0.5MG-2.5MCG
- *fyavolv 0.5mg-2.5mcg tab*
- *hydroxyzine inj 25mg/ml, 50mg/ml*
- *hydroxyzine pamoate cap 25mg, 50mg, 100mg*
- *hydroxyzine syrup 10mg/5ml*
- *jinteli tab 1mg-5mcg*
- LANOXIN TAB 0.25MG
- MENEST TAB 0.3MG, 0.625MG, 1.25MG, 2.5MG
- *metaxall 800mg tab*
- *metaxalone tab 800mg*
- *mimvey LO tab 0.5-0.1mg*
- MINIVELLE PATCH 0.025MG, 0.0375MG, 0.05MG, 0.075MG, 0.1MG
- *orphenadrine citrate inj 30mg/ml*
- PARAFON FORTE DISC 500MG

- *perphenazine/amitriptyline tab 2-10mg, 2-25mg, 4-10mg, 4-25mg, 4-50mg*
- PREFEST TAB 1-0.09MG
- PREMPHASE TAB 0.625-5MG
- *promethazine inj 25mg/ml, 50mg/ml*
- *promethazine syrup 6.25mg/5ml*
- PROMETHAZINE VC SYRUP 6.25-5MG/5ML
- SOMA TAB 350MG
- VIVELLE-DOT PATCH 0.025MG, 0.0375MG, 0.05MG, 0.075MG, 0.1M
- PHENERGAN INJ 25MG/ML, 50MG/ML
- PREMARIN TAB 0.3MG, 0.45MG, 0.625MG, 0.9MG, 1.25MG
- PREMPRO TAB (ALL STRENGTHS)
- *promethazine supp 12.5mg, 25mg, 50mg*
- *promethazine tab 12.5mg, 25mg, 50mg*
- SKELAXIN TAB 800MG
- VISTARIL CAP 25MG, 50MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	Prior Authoration not required for members less than 65 years old.
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	When a high-risk medication is identified, the provider is notified and allowed to attest that they wish to prescribe medication.

Products Affected

- JUXTAPID CAP 30MG, 40MG, 60MG
- JUXTAPID CAP 5MG, 10MG, 20MG
- KYNAMRO INJ 200MG/ML

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Untreated LDL greater than 500 mg/dL OR treated LDL greater than or equal to 300 mg/dL. Concurrent use of maximum statin dose (atorvastatin or Crestor) and one other non-statin alternatives, including bile acid sequestrants, nicotinic acids, and fibric acid derivatives (include dates and reasons for discontinuation). Chart documentation showing the most recent full lipid panel, including Apo-B within the past 12 months.
Age Restrictions	
Prescriber Restriction	Prescriber is a lipidologist affiliated with or has consulted with a lipidologist at a Center for Excellence that manages patients with Homozygous Familial Hypercholesterolemia.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- HUMIRA 40MG/0.8ML AUTO-INJECTOR
- HUMIRA KIT 10MG/0.2ML, 20MG/0.4ML, 40MG/0.8ML
- HUMIRA PEDIATRIC CROHN'S STARTER PACK (3) 40MG/0.8ML I
- HUMIRA PEDIATRIC CROHN'S STARTER PACK (6) 40MG/0.8ML I

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For moderate to severe RA or Psoriatic Arthritis requires intolerance to or failure of therapy with methotrexate (greater than 20mg/wk). Plaque Psoriasis: Failure of, or intolerance to, methotrexate at a dose of 15mg/week or failure of, or intolerance to, soriatane.
Age Restrictions	
Prescriber Restriction	Rheumatoid Arthritis, Psoriatic Arthritis and Ankylosing Spondylitis: Prescriber must be a Rheumatologist. All Plaque Psoriasis: Prescriber must be a Dermatologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	For members with a diagnosis of early, severe-onset RA, additional required medical information is not required.

Products Affected

– IBRANCE CAP 75MG, 100MG, 125MG (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or in consultation with an Oncology Specialist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility
Other Criteria	

Products Affected

- ICLUSIG TAB 15MG, 45MG (New Starts Only)
- ICLUSIG TAB 15MG, 5MG (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or in consult with Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– ILARIS INJ 180MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– IMBRUVICA CAP 140MG (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by an Oncologist or Hemotologist or under the direct consultation of an Oncologist or Hemotologist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– INCRELEX INJ 10MG/ML

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For the long-term treatment of growth failure in children with severe primary insulin-like growth factor-1 (IGF-1) deficiency (primary IGFD) or with growth hormone (GH) gene deletion who have developed neutralizing antibodies to GH.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– INLYTA TAB 1MG, 5MG (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Restricted to or in consult with Oncology Specialist.
Coverage Duration	Covered for duration of plan year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- ESBRIET CAP 267MG
- OFEV CAP 100MG, 150MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Definitive diagnosis of idiopathic pulmonary fibrosis defined by the following: No known cause of lung fibrosis AND one of the following: A. Surgical lung biopsy revealing histopathological pattern of unspecified interstitial pneumonia (UIP) B. High-resolution computed tomography indicates definite UIP pattern C. High-resolution computed tomography indicates possible UIP pattern AND surgical lung biopsy reveals a histopathological pattern of probable UIP
Age Restrictions	
Prescriber Restriction	Prescribed by a Pulmonology Specialist or in consultation with a Pulmonology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	The patient has a FVC less than or equal to 80% of predicted. The patient has a %DLco less than 80% of predicted. Will not be used in combination with other medications used to treat IPF.

Products Affected

– IRESSA 250MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by an Oncology Specialist or in consultation with an Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– ISTODAX INJ 10MG (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or consultation with Hematologist or Oncologist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Approval subject to BvD determination

Products Affected

- *itraconazole cap 100mg*
- SPORANOX CAP PULSEPAK 100MG
- SPORANOX CAP 100MG
- SPORANOX SOLN 10MG/ML

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For onychomycosis or diffuse dermatologic fungal infections: 1. If not prescribed by a Dermatologist or Podiatrist OR fungal infection is confirmed by a positive KOH test. 2. For onychomycosis, must fail terbinafine. For dermatologic infections, must fail one topical antifungal medication.
Age Restrictions	
Prescriber Restriction	Infectious Disease Specialists, Pulmonologist or Dermatologist or have consulted with an Infectious Disease Specialist, Pulmonologist or Dermatologist concerning the patient.
Coverage Duration	Approved for 6 months.
Other Criteria	

Products Affected

– JAKAFI TAB 5MG, 10MG, 15MG, 20MG, 25MG (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Restricted to or in consult with Oncology or Hematology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– KADCYLA INJ 100MG (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Approval will be based off BvD coverage determination.

Products Affected

- KALYDECO PAK 50MG, 75MG
- KALYDECO TAB 150MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Restricted to or in consult with Pulmonology Specialist.
Coverage Duration	Covered for duration of plan year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- KEYTRUDA 100MG/4ML INJ (New Starts Only)
- KEYTRUDA IV SOLN 50MG (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or in consult with Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– KINERET INJ 100MG/0.67ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	If for the treatment of RA, trial or contraindication to 1 TNF-inhibitor (Enbrel or Humira).
Age Restrictions	
Prescriber Restriction	Approval requires the prescriber to be a Rheumatologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– KORLYM TAB 300MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded by Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- KUVAN 100MG POWDER
- KUVAN POWDER PACKET 500MG
- KUVAN TAB 100MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For continuing therapy the patient must have shown a 20% drop in Phenylalanine levels after 2 months of Kuvan treatment.
Age Restrictions	
Prescriber Restriction	Prescribed by a Medical Genecist or other practitioner specialized in the treatment of Phenylketonuria (PKU).
Coverage Duration	Initial = 3 month, then if critieria is met approved for the rest of the plan year
Other Criteria	

Products Affected

– LENVIMA THERAPY PACK 10MG, 14MG, 20MG, 24MG (New Starts

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by an Oncology Specialist or in consultation with an Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– LETAIRIS TAB 5MG, 10MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restriction	Restricted to or in consult with Pulmonologist or Cardiologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- *lidocaine patch 5%*
- LIDODERM PATCH 5%

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Management of neuropathic pain associated with diabetic peripheral neuropathy and postherpetic neuralgia.
Exclusion Criteria	
Required Medical Info	Trial and failure of gabapentin of four weeks or more
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– LINZESS CAP 145MCG, 290MCG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- LONSURF 15-6.14MG TAB (New Starts Only)
- LONSURF 20-8.19MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by an Oncology Specialist or in consultation with an Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– LYNPARZA CAP 50MG (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Restricted to Oncology Specialist or in consult with Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– LYRICA CAP 25MG, 50MG, 75MG, 100MG, 150MG, 200MG, 225MG, – LYRICA SOLN 20MG/ML (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For a diagnosis of diabetic peripheral neuropathy or post herpetic neuralgia. Members must have tried and failed a 4 week minimum trials of gabapentin at doses of at least 1800mg per day. Lyrica is covered when used for the treatment of neuropathic pain associated with spinal cord injury.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– MEKINIST TAB 0.5MG, 2MG (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or in consult with an Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– MOVANTIK TAB 12.5MG, 25MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Initial Therapy: Member must meet all criteria. 1. Opioid-induced constipation. 2. Failed two laxative/bowel therapies -- polyethylene glycol and lactulose.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	4 Months
Other Criteria	

Products Affected

- A-HYDROCORT INJ 100MG
- ABRAXANE IV SUSP 100MG
- *acetylcysteine inhalation soln 10%, 20%*
- *acyclovir inj 50mg/ml*
- AKYNZEO CAP 300-0.5MG
- ALDURAZYME INJ 2.9MG/5ML
- ALKERAN INJ 50MG
- *amifostine inj 500mg*
- *aminophylline inj 25mg/ml*
- AMINOSYN II INJ 7%, 8.5%, 10%, 15%
- AMINOSYN INJ 7%, 10%
- AMINOSYN-RF INJ 5.2%
- *amiodarone inj 150mg/3ml*
- AMPHOTERICIN B INJ 50MG
- AMPICILLIN INJ 125MG
- *ampicillin/sulbactam inj 2-1gm, 10-5gm*
- ANZEMET TAB 50MG, 100MG
- ARALAST NP INJ 400MG
- ARANESP ALBUMIN FREE INJ 100MCG, 150MCG, 200MCG, 300MC
- *argatroban inj 100mg/ml*
- ARRANON INJ 5MG/ML
- ATGAM INJ 50MG/ML
- *atropine inj 0.05mg/ml, 0.1mg/ml*
- AVASTIN INJ 100MG/4ML
- *azacitidine inj 100mg*
- AZACTAM/DEXTROSE INJ 1GM/50ML, 2GM/50ML
- AZATHIOPRINE 10MG/ML INJ
- *azithromycin inj 500mg*
- *baciim inj 50000unit*
- ABELCET INJ 5MG/ML
- *acetazolamide inj 500mg*
- ACTIMMUNE INJ 100MCG/0.5ML
- *adrucil 500mg/10ml inj*
- *albuterol neb 0.63mg/3ml, 1.25mg/3ml, 2.5mg/3ml, 5mg/ml*
- ALIMTA INJ 500MG
- AMBISOME INJ 50MG
- *amikacin sulfate inj 250mg/ml*
- AMINOSYN 7%/ELECTROLYTES
- AMINOSYN II INJ 7%, 8.5%, 10%, 15%
- AMINOSYN M INJ 3.5%
- *aminosyn/electrolyte inj 8.5%*
- AMMONIUM CHLORIDE INJ 5MEQ/ML
- *ampicillin 20mg/ml/sulbactam 10mg/ml inj*
- *ampicillin inj 1gm, 10gm*
- ANZEMET INJ 20MG/ML
- APOKYN INJ 10MG/ML
- ARANESP 10MCG/0.4ML SYR
- ARANESP ALBUMIN FREE INJ 25MCG, 40MCG, 60MCG
- ARGATROBAN INJ 125MG/125ML
- ASTAGRAF XL CAP 0.5MG, 1MG, 5MG
- *atropine inj 0.05mg/ml, 0.1mg/ml*
- AVASTIN 400MG/16ML INJ
- AVELOX INJ 400MG/250ML
- AZACTAM INJ 1GM
- AZASAN TAB 75MG, 100MG
- *azathioprine tab 50mg*
- *aztreonam inj 1gm*
- BACITRACIN INJ 50000UNIT

- BCG VACCINE INJ
- BENTYL INJ 10MG/ML
- BICILLIN C-R INJ 1200000UNIT/2ML
- BICNU INJ 100MG
- BONIVA INJ 3MG/3ML
- *budesonide 0.5 mg/ml inh soln*
- *bumetanide inj 0.25mg/ml*
- *buprenorphine inj 0.3mg/ml*
- *butorphanol inj 1mg/ml, 2mg/ml*
- *calcitriol inj 1mcg/ml*
- CAMPTOSAR INJ 100MG/5ML
- CAPASTAT INJ 1GM
- CARDENE INJ 20MG/200ML, 40MG/200ML
- CARNITOR SOLN 1GM/10ML
- *cefazolin 1000mg inj*
- CEFAZOLIN/D5W INJ 1GM/50ML
- CEFEPIME 40MG/ML INJ
- *cefotaxime inj 500mg, 1gm, 2gm, 10gm*
- *cefoxitin inj 1gm, 2gm, 10gm*
- *ceftazidime inj 1gm, 2gm, 6gm*
- *ceftriaxone inj 250mg, 500mg, 1gm, 2gm, 10gm*
- CELLCEPT CAP 250MG
- CELLCEPT SUSP 200MG/ML
- CEREBYX INJ 500MG/10ML
- CHLORAMPHENICAL INJ 1GM
- *chlorpromazine inj 25mg/ml*
- CIPRO/D5W INJ 400MG/200ML
- *ciprofloxacin/D5W inj 200mg/100ml*
- *cladribine inj 1mg/ml*
- CLAFORAN INJ 500MG, 1GM, 2GM, 10GM
- BENLYSTA INJ 120MG
- *benztropine inj 1mg/ml*
- BICILLIN L-A INJ 600000UNIT/ML
- *bleomycin sulfate inj 30unit*
- BROVANA NEB 15MCG/2ML
- *budesonide neb 0.25mg/2ml, 0.5mg/2ml*
- BUPRENEX INJ 0.3MG/ML
- BUSULFEX INJ 6MG/ML
- *calcitriol cap 0.25mcg, 0.5mcg*
- *calcitriol soln 1mcg/ml*
- CANCIDAS INJ 50MG, 70MG
- *carboplatin inj 150mg/15ml*
- CARNITOR INJ 200MG/ML
- CARNITOR TAB 330MG
- *cefazolin inj 500mg, 1gm, 10mg*
- CEFEPIME 20MG/ML INJ
- *cefepime inj 1gm, 2gm*
- CEFOTETAN INJ 1GM, 2GM, 10GM
- CEFOXITIN/DEXTROSE INJ 1GM-4%, 2GM-2.2%
- CEFTAZIDIME/DEXTROSE INJ 1GM/50ML, 2GM/50ML
- *cefuroxime inj 750mg, 1.5gm, 7.5gm*
- CELLCEPT IV INJ 500MG
- CELLCEPT TAB 500MG
- CEREZYME INJ 400UNIT
- *chlorothiazide inj 500mg*
- *cidofovir inj 75mg/ml*
- *ciprofloxacin IV soln 400mg/40ml*
- *cisplatin inj 1mg/ml*
- CLAFORAN INJ 500MG, 1GM, 2GM, 10GM
- CLEOCIN PHOSPHATE INJ 900MG/6ML

- CLEOCIN/D5W INJ 300MG/50ML, 600MG/50ML, 900MG/50ML
- *clindamycin/d5w inj 300mg/50ml, 600mg/50ml, 900mg/50ml*
- CLINIMIX E INJ 2.75%, 4.25%, 5%
- CLINIMIX INJ 4.25%, 5%
- CLOLAR INJ 1MG/ML
- *colistimethate inj 150mg*
- *cromolyn neb 20mg/2ml*
- CYCLOPHOSPHAMIDE CAP 25MG, 50MG
- *cyclosporine inj 50mg/ml*
- CYCLOSPORINE MODIFIED CAP 50MG
- CYKLOKAPRON INJ 100MG/ML
- CYTOVENE INJ 500MG
- *d5w/lactated ringers inj*
- D5W/NACL INJ 0.2%, 0.45%
- DACOGEN INJ 50MG
- *daunorubicin inj 5mg/ml*
- *decitabine inj 50mg*
- DELESTROGEN INJ 10MG/ML, 20MG/ML, 40MG/ML
- DEPO ESTRADIOL INJ 5MG/ML
- DEPO-MEDROL INJ 20MG/ML, 40MG/ML, 80MG/ML
- *desmopressin inj 4mcg/ml*
- *dexamethasone inj 10mg/ml, 120mg/30ml*
- *dextrose inj 5%, 10%*
- DILAUDID INJ 2MG/ML, 4MG/ML
- *diltiazem inj 50mg/10ml*
- DOCEFREZ INJ 20MG, 80MG
- DOCETAXEL INJ 20MG/ML
- *doxercalciferol cap 0.5mcg, 1mcg, 2.5mcg*
- DOXIL INJ 2MG/ML
- *doxycycline inj 100mg*
- *clindamycin inj 600mg/4ml*
- CLINIMIX E 4.25%/DEXTROSE INJ
- CLINIMIX INJ 2.75%
- *clinisol sf inj 15%*
- COGENTIN INJ 1MG/ML
- COSMEGEN INJ 0.5MG
- CUBICIN INJ 500MG
- *cyclosporine cap 25mg, 100mg*
- *cyclosporine modified cap 25mg, 100mg*
- *cyclosporine modified soln 100mg/ml*
- *cytarabine inj 20mg/ml, 100mg/ml*
- *d2.5w/nacl inj 0.45%*
- *d5w/nacl inj 0.2%, 0.33%, 0.45%, 0.9%*
- *dacarbazine inj 200mg*
- DALVANCE INJ 500MG
- DDAVP INJ 4MCG/ML
- DELESTROGEN INJ 10MG/ML, 20MG/ML, 40MG/ML
- DEPACON INJ 100MG/ML
- DEPO-MEDROL INJ 20MG/ML, 40MG/ML, 80MG/ML
- DEPO-TESTOSTERONE INJ 100MG/ML, 200MG/ML
- *dexamethasone inj 10mg/ml, 120mg/30ml*
- *dexrazoxane inj 10mg/ml*
- *dihydroergotamine mesylate inj 1mg/ml*
- DILTIAZEM INJ 100MG
- *diphenhydramine inj 50mg/ml*
- DOCETAXEL INJ 10MG/ML
- DORIBAX INJ 500MG
- *doxercalciferol inj 2mcg/ml*
- *doxorubicin inj 2mg/ml*
- *duramorph inj 0.5mg/ml, 1mg/ml*

- ELAPRASE INJ 2MG/ML
- ELITEK INJ 1.5MG
- EMEND CAP 40MG, 80MG, 125MG
- ENGERIX-B INJ
- ENVARSUS 1MG ER TAB
- *epirubicin inj 2mg/ml*
- ERAXIS INJ 100MG
- ERYTHROCIN LACTOBIONATE INJ 500MG
- *esomeprazole inj 20mg, 40mg*
- ETOPOPHOS INJ 100MG
- FABRAZYME INJ 35MG
- FAMOTIDINE/NACL INJ 0.9%-20MG/50ML
- *fat emulsion IV soln 20%*
- *fludarabine inj 50mg*
- *fluphenazine decanoate inj 25mg/ml*
- *fomepizole inj 1gm/ml*
- *fosphenytoin inj 100mg/2ml*
- FRAGMIN INJ 5000UNIT, 125000UNIT, 15000UNIT, 18000UNIT
- *furosemide inj 10mg/ml*
- *ganciclovir inj 500mg*
- GEMZAR INJ 1GM
- *gengraf soln 100mg/ml*
- *gentamicin/nacl inj 0.8mg/ml, 1mg/ml, 1.2mg/ml, 1.6mg/ml*
- GEODON INJ 20MG
- *glycopyrrolate inj 4mg/20ml*
- *granisetron tab 1mg*
- HALAVEN INJ 1MG/2ML
- HALDOL INJ 5MG/ML
- *haloperidol inj 5mg/ml*
- HECTOROL INJ 4MCG/2ML
- ELIGARD INJ 7.5MG, 22.5MG, 30MG, 45MG
- ELLENCE INJ 2MG/ML
- EMEND CAP THERAPY PACK
- ENVARSUS 0.75MG ER TAB
- ENVARSUS 4MG ER TAB
- EPOGEN INJ 2000UNIT/ML, 3000UNIT/ML, 4000UNIT/ML, 10000UN
- ERBITUX SOLN 100MG/50ML
- *esomeprazole inj 20mg, 40mg*
- *estradiol valerate inj 20mg/ml, 40mg/ml*
- *etoposide inj 20mg/ml*
- *famotidine inj 20mg/2ml*
- FASLODEX INJ 250MG/5ML
- *fluconazole 2mg/ml inj*
- *fluorouracil inj 50mg/ml*
- *fluphenazine inj 2.5mg/ml*
- FORTAZ INJ 1GM, 2GM, 6GM
- FRAGMIN INJ 2500UNIT, 10000UNIT
- FREAMINE HBC 6.9%
- FUSILEV INJ 50MG
- *gemcitabine inj 1gm*
- *gengraf cap 25mg, 100mg*
- *gentamicin inj 10mg/ml, 40mg/ml*
- GENTAMICIN/NACL INJ 0.9MG/ML, 1.4MG/ML
- GLASSIA INJ 1000MG/50ML
- *granisetron inj 0.1mg/ml, 1mg/ml*
- GRANIX INJ 300MCG, 480MCG
- HALDOL DECANOATE INJ 50MG/ML, 100MG/ML
- *haloperidol decanoate inj 50mg/ml, 100mg/ml*
- HECTOROL CAP 0.5MCG, 1MCG, 2.5MCG
- *heparin inj 1000unit/ml, 5000unit/ml, 10000unit/ml, 20000unit/ml*

- *heparin/d5w inj 40unit/ml, 50unit/ml, 100unit/ml*
- HERCEPTIN INJ 440MG
- *hydralazine inj 20mg/ml*
- *ibandronate inj 3mg/3ml*
- *idarubicin inj 1mg/ml*
- *ifosfamide inj 1gm*
- IMOVAX RABIES (H.D.C.V) INJ
- *intralipid inj 20%*
- INTRON-A INJ 18000000UNIT, 50000000UNIT
- INVANZ INJ 1GM
- IONOSOL-MB/D5W INJ
- *ipratropium/albuterol soln 0.5-2.5mg/3ml*
- ISOLYTE-S INJ
- IXEMPRA INJ 45MG
- KCL 0.15%/D5W/NACL 0.225%
- KCL/D5W/LR 20MEQ
- KENALOG INJ 10MG/ML, 40MG/ML
- *labetalol inj 5mg/ml*
- *lactated ringers soln*
- LEUKINE INJ 250MCG
- *levalbuterol neb 0.31mg/3ml, 0.63mg/3ml*
- LEVETIRACETAM 10MG/ML INJ
- LEVETIRACETAM 5MG/ML INJ
- *levocarnitine inj 200mg/ml*
- *levocarnitine tab 330mg*
- *levofloxacin inj 25mg/ml*
- LEVOLEUCOVORIN INJ 10MG/ML
- LINCOCIN INJ 300MG/ML
- *liothyronine inj 10mcg/ml*
- LUPRON DEPOT INJ 3.75MG, 7.5MG, 11.25MG, 22.5MG, 30MG, 45M
- *hepatamine inj 8%*
- HYCAMTIN INJ 4MG
- *hydromorphone inj 10mg/ml*
- IDAMYCIN PFS INJ 1MG/ML
- IFEX INJ 1GM
- *imipenem/cilastatin inj 250mg, 500mg*
- IMURAN TAB 50MG
- INTRALIPID INJ 30%
- INTRON-A INJ 6000000UNIT, 10000000UNIT
- IONOSOL-B/D5W INJ
- *ipratropium inhalation soln 0.02%*
- *irinotecan inj 20mg/ml*
- ISOLYTE/D5W INJ
- JEVTANA INJ 60MG/1.5ML
- KCL 0.3%/D5W/NACL 0.9%
- *kcl/d5w/nacl inj*
- KEPIVANCE INJ 6.25MG
- *lactated ringers irrigation*
- *leucovorin inj 100mg, 350mg*
- *leuprolide inj 5mg/ml*
- *levalbuterol neb conc 1.25mg/0.5ml*
- LEVETIRACETAM 15MG/ML INJ
- *levetiracetam inj 500mg/5ml*
- *levocarnitine soln 1gm/10ml*
- *levofloxacin 5mg/ml (150ml) inj*
- *levofloxacin inj 25mg/ml, 500mg/100ml*
- *lidocaine inj 0.5%, 1%, 2%*
- *lincomycin 300mg/ml inj*
- LUMIZYME INJ 50MG
- LUPRON DEPOT PEDIATRIC INJ 11.25MG, 15MG

- *magnesium sulfate inj 50%*
- *melphalan inj 50mg*
- MERREM INJ 500MG
- MESNEX INJ 100MG/ML
- *methylprednisolone inj 40mg/ml, 80mg/ml*
- *metoclopramide inj 5mg/ml*
- *metoprolol tartrate inj 1mg/ml*
- MIACALCIN INJ 200UNIT/ML
- *mitoxantrone inj 2mg/ml*
- MORPHINE SULFATE PF INJ 8MG/ML, 10MG/ML
- MOZOBIL INJ 20MG/ML
- MYCAMINE INJ 50MG, 100MG
- *mycophenolate mofetil susp 200mg/ml*
- *mycophenolate tab 500mg*
- MYOZYME INJ 50MG
- NAFCILLIN/DEXTROSE INJ 1GM/50ML
- NEBUPENT NEB 300MG
- NEORAL SOLN 100MG/ML
- NEULASTA INJ 6MG/0.6ML
- NEXIUM INJ 20MG, 40MG
- *nicardipine inj 2.5mg/ml*
- *normosol-M/dextrose inj*
- NORMOSOL-R/DEXTROSE INJ
- *octreotide inj 50mcg, 100mcg, 200mcg, 500mcg, 1000mg*
- ONCASPAR INJ 750UNIT/ML
- *ondansetron inj 4mg/2ml*
- *ondansetron soln 4mg/5ml*
- *ondansetron tab 4mg, 8mg*
- OXACILLIN/DEXTROSE INJ 1GM/50ML, 2GM/50ML
- *paclitaxel inj 6mg/ml*
- MAXIPIME INJ 1MG, 2MG
- *meropenem inj 500mg*
- *mesna inj 100mg/ml*
- METHADONE INJ 10MG/ML
- *methylprednisolone sodium succinate inj 40mg, 125mg*
- *metoprolol tartrate 1mg/ml cartridge*
- *metronidazole/nacl inj 500mg/100ml*
- *mitomycin inj 20mg*
- *morphine sulfate PF inj 2mg/ml, 4mg/ml*
- MOXIFLOXACIN 1.6MG/ML INJ
- MUSTARGEN INJ 10MG
- *mycophenolate cap 250mg*
- *mycophenolate sodium tab 180mg, 360mg*
- MYFORTIC TAB 180MG, 360MG
- *nafcillin inj 1gm, 10gm*
- NAGLAZYME INJ 1MG/ML
- NEORAL CAP 25MG, 100MG
- NEPHRAMINE INJ 5.4%
- NEUPOGEN INJ 300MCG/ML, 600MCG/ML
- NEXTERONE INJ 150MG/100ML, 360MG/200ML
- NIPENT INJ 10MG
- NORMOSOL-R INJ
- NULOJIX INJ 250MG
- *olanzapine inj 10mg*
- *ondansetron 2mg/ml syr*
- *ondansetron ODT 4mg, 8mg*
- *ondansetron tab 24mg*
- *oxacillin inj 2gm, 10gm*
- *oxaliplatin inj 100mg/20ml*
- *pamidronate inj 3mg/ml, 9mg/ml*

- PAMIDRONATE INJ 6MG/ML
- PARICALCITOL INJ 2MCG/ML
- PENICILLIN G/DEXTROSE INJ 40000UNIT, 60000UNIT
- PENICILLIN G/SODIUM INJ 50000000UNIT
- PERFOROMIST NEB 20MCG/2ML
- *physiolyte irrigation soln*
- *piperacillin/tazobactam inj 3-0.375mg, 4-0.5mg*
- PLASMA-LYTE/D5W INJ
- *polymyxin B sulfate inj 500000unit*
- *potassium chloride inj 2meq*
- *potassium chloride/d5w inj 0.15%, 0.225%, 0.3%*
- *potassium chloride/nacl inj 0.15/0.9%, 0.3/0.9%*
- PREMASOL SOLN 10%
- PRIMAXIN INJ 250MG, 500MG
- PROCALAMINE INJ 3%
- PROCRIT INJ 2000UNIT/ML, 3000UNIT/ML, 4000UNIT/ML, 10000UN
- PROGRAF INJ 5MG/ML
- PROLEUKINE IV SOLN 22000000UNIT
- *propranolol inj 1mg/ml*
- PULMICORT NEB 0.25MG/2ML, 0.5MG/2ML
- PULMOZYME SOLN 1MG/ML
- RABAVERT INJ
- RAPAMUNE SOLN 1MG/ML
- RAPAMUNE TAB 1MG, 2MG
- RECOMBIVAX-HB INJ
- RIFADIN INJ 600MG
- *ringers injection*
- RISPERDAL INJ 12.5MG, 25MG, 37.5MG, 50MG
- ROBINUL 0.4MG/2ML INJ
- ROCALTROL SOLN 1MCG/ML
- *paricalcitol cap 1mcg, 2mcg, 4mcg*
- *penicillin g potassium inj 5000000unit*
- PENICILLIN G/PROCAINE INJ 600000UNIT
- PENTAM INJ 300MG
- *phenytoin inj 50mg/ml*
- *physiosol irrigation soln*
- PLASMA-LYTE INJ
- *plenamine 15% inj*
- POTASSIUM CHLORIDE INJ 10MEQ, 20MEQ, 40MEQ
- *potassium chloride/d5w inj 0.15%, 0.225%, 0.3%*
- *potassium chloride/nacl inj 0.15-0.45%*
- PREMARIN INJ 25MG
- *premasol soln 6%*
- *procainamide inj 100mg/ml, 500mg/ml*
- *prochlorperazine inj 5mg/ml*
- PROGRAF CAP 0.5MG, 1MG, 5MG
- PROLASTIN-C INJ 1000MG
- PROLIA SOLN 60MG/ML
- PROSOL INJ 20%
- PULMICORT NEB 1MG/2ML
- *quinidine gluconate inj 80mg/ml*
- *ranitidine inj 25mg/ml*
- RAPAMUNE TAB 0.5MG
- RECLAST INJ 5MG/100ML
- REMODULIN INJ 1MG/ML, 2.5MG/ML, 5MG/ML, 10MG/ML
- *rifampin inj 600mg*
- *ringers irrigation*
- RITUXAN INJ 10MG/ML
- ROCALTROL CAP 0.25MCG, 0.5MCG
- SANDIMMUNE CAP 25MG, 100MG

- SANDIMMUNE INJ 50MG/ML
- SANDOSTATIN INJ 50MCG/ML, 100MCG/ML, 200MCG/ML, 500MC
- SIMULECT INJ 20MG
- *sodium chloride inj 0.45%, 0.9%, 3%, 5%, 14.6%*
- SODIUM DIURIL INJ 500MG
- SOLU-CORTEF INJ 100MG
- SOLU-MEDROL INJ 40MG, 125MG, 500MG, 2000MG
- SOMATULINE DEPOT INJ 60MG/0.2ML, 90MG/0.3ML, 120MG/0.5M
- *sterile water irrigation*
- SULFAMETHOXAZOLE/TRIMETHOPRIM INJ 400-80MG/5ML
- SYNERCID INJ 500MG
- *tacrolimus cap 0.5mg, 1mg, 5mg*
- *tazicef 1gm inj*
- *tazicef 6gm inj*
- TENIVAC SYR
- *testosterone cypionate inj 100mg/ml, 200mg/ml*
- THIOTEPA 15MG INJ
- *tobramycin inj 10mg/ml, 80mg/2ml*
- *topotecan inj 4mg*
- *tpn electrolytes soln*
- TRAVASOL INJ 10%
- TRELSTAR LA MIXJECT INJ 11.25MG
- TRIOSTAT INJ 0.01MG/ML
- TROPHAMINE INJ 6%, 10%
- TWINRIX INJ
- TYSABRI INJ 20MG/ML
- UVADEX SOLN 20MCG/ML
- *vancomycin inj 500mg, 1000mg, 10gm*
- VECTIBIX INJ 100MG/5ML
- *verapamil inj 2.5mg/ml*
- SANDIMMUNE SOLN 100MG/ML
- SANDOSTATIN LAR DEPOT INJ KIT 10MG, 20MG, 30MG
- *sirolimus tab 0.5mg 1mg, 2mg*
- *sodium chloride irrigation soln 0.9%*
- *sodium lactate inj 5meq/ml*
- SOLU-CORTEF INJ 250MG
- SOLU-MEDROL INJ 40MG, 125MG, 500MG, 2000MG
- SOMAVERT INJ 10MG, 15MG, 20MG, 25MG, 30MG
- STREPTOMYCIN INJ 1GM
- SYLVANT INJ 100MG
- SYNRIBO INJ 3.5MG
- TAXOTERE INJ 80MG/4ML
- *tazicef 2gm inj*
- TEFLARO IV SOLN 400MG, 600MG
- *terbutaline inj 1mg/ml*
- *testosterone enanthate inj 200mg/ml*
- THYMOGLOBULIN INJ 25MG
- *toposar inj 1gm/50ml*
- TORISEL SOLN 25MG/ML
- *tranexamic acid inj 100mg/ml*
- TRELSTAR DEPOT MIXJECT INJ 3.75MG
- TRELSTAR MIXJECT INJ 22.5MG
- TRISENOX INJ 10MG/10ML
- TROPHAMINE INJ 6%, 10%
- TYGACIL INJ 50MG
- UNASYN INJ 2-1GM, 10-5GM
- *valproic acid inj 100mg/ml*
- VARUBI 90MG TAB
- VELCADE INJ 3.5MG
- VIDAZA INJ 100MG

- VIMPAT INJ 10MG/ML
- *vincasar PFS inj 1mg/ml*
- *vinorelbine inj 10mg/ml*
- VISTIDE INJ 75MG/ML
- XOPENEX NEB 0.31MG/3ML, 0.63MG/3ML, 1.25MG/3ML
- ZANOSAR INJ 1GM
- ZARXIO 300MCG/0.5ML SYR
- ZEMAIRA INJ 1000MG
- ZEMPLAR INJ 2MCG/ML, 5MCG/ML
- ZINECARD INJ 250MG
- ZOFRAN INJ 40MG/20ML
- ZOFRAN SOLN 4MG/5ML
- *zoledronic acid inj 5mg/100ml*
- ZOMETA INJ 4MG/100ML, 4MG/5ML
- ZOSYN INJ 3-0.375GM
- ZYPREXA 210MG INJ
- VINBLASTINE INJ 1MG/ML
- *vincristine inj 1mg/ml*
- VIRAZOLE SOLN 6GM
- VPRIV INJ 400UNIT
- XYLOCAINE INJ 2%
- ZANTAC INJ 25MG/ML
- ZARXIO 480MCG/0.8ML SYR
- ZEMPLAR CAP 1MCG, 2MCG, 4MCG
- ZINACEF INJ 750MG, 1.5GM, 7.5GM
- ZITHROMAX INJ 500MG
- ZOFRAN ODT 4MG, 8MG
- ZOFRAN TAB 4MG, 8MG
- *zoledronic acid inj conc 4mg/5ml*
- ZOMETA INJ 4MG/100ML, 4MG/5ML
- ZOSYN/DEXTROSE INJ 2-0.25GM/ML, 3-0.375GM/50ML
- ZYPREXA INJ 10MG

PA Criteria	Criteria Details
Covered Uses	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	
Other Criteria	

Products Affected

– NATPARA INJ 25MCG, 50MCG, 75MCG, 100MCG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or in consult with Endocrinologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– NEXAVAR TAB 200MG (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	Require patient to be at least 18 years old.
Prescriber Restriction	Prescribed by a Oncologist or under the direct consultation of an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- NINLARO 2.3MG CAP (New Starts Only)
- NINLARO 3MG CAP (New Starts Only)
- NINLARO 4MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by an Oncology Specialist or Hematology Specialist, or in consultation with an Oncology Specialist or Hematology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– NORTHERA CAP 100MG, 200MG, 300MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by a Neurology Specialist or in consultation with a Neurology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- NOXAFIL SUSP 40MG/ML
- NOXAFIL TAB 100MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- *modafinil tab 100mg, 200mg*
- PROVIGIL TAB 100MG, 200MG
- NUVIGIL TAB 50MG, 150MG, 200MG, 250MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis of narcolepsy, OR obstructive sleep apnea/hypopnea syndrome, OR shift work sleep disorder
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– ODOMZO 200MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by an Oncology Specialist or in consultation with an Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- ONFI SUSP 2.5MG/ML (New Starts Only)
- ONFI TAB 10MG, 20MG (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA Approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– OPDIVO INJ 40MG/4ML (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Restricted to Oncology Specialist or in consult with Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– OPSUMIT TAB 10MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restriction	Restricted to or in consult with Pulmonologist or Cardiologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- ABSTRAL TAB 100MG, 200MG, 300MG, 400MG, 600MG, 800MG
- *fentanyl lollipop 200mcg, 400mcg, 600mcg, 800mcg, 1200mcg, 1600mcg*
- LAZANDA NASAL SPRAY 100MCG, 400MCG
- ACTIQ 200MCG, 400MCG, 600MCG, 800MCG, 1200MCG, 1600MCG
- FENTORA TAB 100MCG, 200MCG, 400MCG, 600MCG, 800MCG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Breakthrough cancer pain and opioid tolerence. Documented tolerance to opioids defined as patients taking around the clock medicine consisting of at least 60mg of oral morphine daily, at least 25mcg of transdermal fentanyl per hour, at least 30mg of oxycodone daily, at least 8mg of oral hydromorphone daily, or an equianalgesic dose of another opioid daily for a week or longer.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Quantity Limit of 120 lozenges per 30 days.

Products Affected

- ORENCIA INJ 250MG
- ORENCIA SC INJ 125MG/ML

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For moderate to severe RA intolerance to or failure of therapy with Enbrel OR Humira. For Polyarticular Juvinal Idiopathic Arthritis intolerance to or failure of therapy with Enbrel.
Age Restrictions	
Prescriber Restriction	Prescribed by or in consultation with Rheumatology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– ORFADIN CAP 2MG, 5MG, 10MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– ORKAMBI 200-125MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	1) Lung function (FEV1, ppFEV1), 2) BMI, 3) Pulmonary exacerbation history to be collected initially and at continuation.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, pulmonologist.
Coverage Duration	Initial and continuation approval of 6 months to assess required medical info
Other Criteria	

Products Affected

- OTEZLA 28-DAY STARTER PACK
- OTEZLA TAB 30MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member must have tried Enbrel AND Humira
Age Restrictions	
Prescriber Restriction	Prescribed by or on consult with Rheumatology Specialist or Dermatology Specialist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– PERJETA INJ 30MG/ML (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or in consult with Hematology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– POMALYST CAP 1MG, 2MG, 3MG, 4MG (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded by Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or in consult with Hematology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– POTIGA TAB 50MG, 200MG, 300MG, 400MG (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- CRINONE 4% VAGINAL GEL
- CRINONE 8% VAGINAL GEL

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– PROMACTA TAB 12.5MG, 25MG, 50MG, 75MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Patient has chronic idiopathic thrombocytopenia purpura AND patient has failed one prior ITP therapy glucocorticoids, intravenous immunoglobulin, or splenectomy OR a diagnosis of chronic Hep-C assoicated thrombocytopenia.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– RAVICTI LIQUID 1.1GM/ML

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Requires trial of sodium phenylbutyrate powder.
Age Restrictions	
Prescriber Restriction	Prescribed by a Metabolic Specialist or in consultation with a Metabolic Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- RELISTOR 12MG/0.6ML SYR
- RELISTOR 8MG/0.4ML SYR
- RELISTOR INJ 20MG/ML

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Initial Therapy: Member must meet both of the following: 1.Opioid-induced constipation. 2. Trial, or intolerance to, 2 laxative/bowel therapies -- polyethylene glycol + Lactulose.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	4 Months
Other Criteria	

Products Affected

– REMICADE INJ 100MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For the treatment of RA member must have tried and failed Enbrel and Humira. For the treatment of Plaque Psoriasis, Psoriatic Arthritis or ankylosing spondylitis must have tried and failed Enbrel. For the treatment of Crohn's Disease must have tried and failed Humira
Age Restrictions	Rheumatoid arthritis require the patient to be at least 18 years of age.
Prescriber Restriction	Rheumatoid Arthritis, Psoriatic Arthritis, Reactive Arthritis and Ankylosing Spondylitis= prescriber must be a Rheumatologist. Crohn's Disease or Ulcerative Colitis= prescriber must be a Gastroenterologist. Plaque Psoriasis= prescriber must be a Dermatologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	For members with Ulcerative Colitis additional required medical information is not required.

Products Affected

- REVATIO INJ 10MG/12.5ML
- *sildenafil inj 0.8mg/ml*
- REVATIO TAB 20MG
- *sildenafil tab 20mg*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Primary Pulmonary Arterial Hypertension or Secondary Pulmonary Arterial Hypertension.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- REVLIMID CAP 2.5MG, 20MG (New Starts Only)
- REVLIMID CAP 5MG, 10MG, 15MG, 25MG (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Restricted to or in consult with Oncologist or Hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- REXULTI 0.25MG TAB (New Starts Only)
- REXULTI 0.5MG TAB (New Starts Only)
- REXULTI 1MG TAB (New Starts Only)
- REXULTI 2MG TAB (New Starts Only)
- REXULTI 3MG TAB (New Starts Only)
- REXULTI 4MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Trial of two (2) of the following: olanzapine, quetiapine, risperidone, aripiprazole or ziprasidone.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– ROZEREM TAB 8MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For approval, a prior use of zolpidem is required OR patient has had history of scheduled drug dependence
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of the contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– RUCONEST INJ 2100UNIT

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– SIGNIFOR INJ 0.3MG/ML, 0.6MG/ML, 0.9MG/ML

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded by Part D.
Exclusion Criteria	
Required Medical Info	Prescribed for the treatment of an adult patient with Cushing disease AND Pituitary surgery is not an option OR Pituitary surgery was not curative
Age Restrictions	
Prescriber Restriction	Prescribed by or in consult with an endocrinologist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- SIMPONI ARIA IV SOLN 50MG/4ML
- SIMPONI AUTO-INJECTOR INJ 50MG/0.5ML, 100MG/ML
- SIMPONI INJ 50MG/0.5ML, 100MG/ML

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For moderate to severe RA, Psoriatic Arthritis, and ankylosing arthritis intolerance to or failure of therapy with Enbrel AND Humira.
Age Restrictions	
Prescriber Restriction	Prescribed by a Rheumatology Specialist, Gasteroenterologist or Dermatologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- SIVEXTRO INJ 200MG
- SIVEXTRO TAB 200MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Restricted to Infectious Disease Specialist or in consult with Infectious Disease Specialist.
Coverage Duration	Approved for 6 months subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– SOLTAMOX ORAL SOLN 10MG/5ML (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded by Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– SOVALDI TAB 400MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Patient is diagnosed with chronic HCV (greater than 6 months) with genotype indicated 2) Current HCV-RNA titer
Age Restrictions	member must be 18 years of age or older
Prescriber Restriction	Prescribed by, or in consultation with, a Gastroenterologist, Hepatologist, Infectious Disease or Transplant Specialist
Coverage Duration	Coverage of 12 to 48 weeks based on genotype and treatment as defined by current AASLD guidelines.
Other Criteria	Treatment regimen will be approved based on genotype and previous treatment experience as defined by current AASLD guidelines.

Products Affected

– SPRYCEL TAB 20MG, 50MG, 70MG, 80MG, 100MG, 140MG (New Sta

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	The criteria require the diagnosis of either chronic myeloid leukemia in a patient who is resisitant or intolerant to prior therapy including Gleevec or a diagnosis of Lymphoblastic Leukemia in a patient who is resistant or intolerant to prior therapy. For the treatment of adults with newly diagnosed Ph+ chronic myeloid leukemia (CML) in chronic phase
Age Restrictions	Approval of Sprycel require the patient to be at least 18 years old.
Prescriber Restriction	Sprycel require the prescriber to be an Oncologist or Hematologist or be in under the direct consultation with an Oncologist or Hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- STELARA INJ 45MG/0.5ML
- STELARA INJ 90MG/ML

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Patient has tried or was intolerant to Enbrel AND Humira
Age Restrictions	
Prescriber Restriction	Prescribed by a Rheumatology Specialist or Dermatologist or in consultation with a Rheumatology Specialist or Dermatologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– STIVARGA TAB 40MG (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or in consult with Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- STRENSIQ 40MG/ML INJ
- STRENSIQ 80MG/0.8ML INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a Pediatric Endocrinologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– SUTENT CAP 12.5MG, 25MG, 37.5MG, 50MG (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	Sutent requires the patient to be at least 18 years old.
Prescriber Restriction	Sutent requires the prescriber to be an Oncologist or under the direct consultation of an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– SYLATRON INJ 296MCG, 444MCG, 888MCG (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or in consult with an Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– SYNAGIS INJ 50MG/0.5ML

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Approve up to five (MAXIMUM) monthly doses of Synagis when an infant or child meets the criteria for one of the following conditions: Infants and children younger than 24 months with chronic lung disease of prematurity (CLD previously known as bronchopulmonary dysplasia) receiving medical therapy within 6 months before the start of the RSV season OR Infants born before 32 weeks of gestation even if they do not have CLD OR Infants born at 32 to less than 35 weeks of gestation, particularly when at least 1 of the following 2 risk factors is present: the infant attends child care, or 1 or more siblings or other children younger than 5 years live permanently in the same household OR Infants with congenital abnormalities of the airway or neuromuscular disease OR Infants and children 24 months or younger with hemodynamically significant cyanotic or acyanotic congenital heart disease (CHD).
Age Restrictions	
Prescriber Restriction	Synagis approval if IICU physician or a Neonatologist or if upon consultation with a Pediatric Specialist or Pediatric Pulmonologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– TAFINLAR CAP 50MG, 75MG (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or in consult with an Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- TAGRISSO 40MG TAB (New Starts Only)
- TAGRISSO 80MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by an Oncology Specialist or in consultation with an Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– TARCEVA TAB 25MG, 100MG, 150MG (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Prescribed by or in consultation with an Oncologist/Hematologist AND prescribed for one of the following: 1. metastatic non–small cell lung cancer in which tumors have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations as detected by an Food and Drug Administration (FDA)–approved test. 2. maintenance treatment of locally advanced or metastatic non–small cell lung cancer when disease has not progressed after 4 cycles of platinum-based first-line chemotherapy. 3. treatment of locally advanced or metastatic non–small cell lung cancer after failure of at least 1 prior chemotherapy regimen. 4. First-line treatment of locally advanced, unresectable or metastatic pancreatic cancer in combination with gemcitabine.
Age Restrictions	
Prescriber Restriction	Prescribed by or in consult with Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- *bexarotene 75mg cap (New Starts Only)*
- TARGRETIN CAP 75MG (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Restricted to or in consult with Oncology or Dermatology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– TASIGNA CAP 150MG, 200MG (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	The criteria require the diagnosis of either chronic myeloid leukemia in a patient who is resisitant or intolerant to prior therapy including Gleevec. For the treatment of adults with newly diagnosed Ph+ chronic myeloid leukemia (CML) in chronic phase.
Age Restrictions	
Prescriber Restriction	Board Certified Oncologist/Hematologist or under the direct consultation with one.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– THALOMID CAP 50MG, 100MG, 150MG, 200MG (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Restricted to or in consult with Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- TOBI NEB 300MG/5ML
- TOBI PODHALER 28MG
- *tobramycin neb 300mg/5ml*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Restricted to or in consult with Infectious Disease or Pulmonology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Approval will be based off BvD coverage determination.

Products Affected

– TRACLEER TAB 62.5MG, 125MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Restricted to or in consult with Pulmonology or Cardiology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– TREANDA INJ 45MG, 100MG (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- QUDEXY XR CAP 25MG, 50MG, 100MG, 150MG, 200MG (New Starts
- TOPIRAMATE ER CAP 25MG, 50MG, 100MG, 150MG, 200MG (New S
- TROKENDI XR CAP 25MG, 50MG, 100MG, 200MG (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Patient has tried and failed topiramate (TOPAMAX) AND Patient has a diagnosis of partial-onset seizures, primary generalized tonic-clonic seizures, or seizures associated with Lennox-Gastaut syndrome
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– TYKERB TAB 250MG (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Tykerb is prescribed in combination with capecitabine (Xeloda) AND The patient has advanced or metastatic breast cancer with tumor over-expression of HER2 AND The patient has recieved prior therapy including an anthracycline and a taxane and trastumab. Tykerb is prescribed in combination with letrozole for the treatment of postmenopausal women with hormone receptor positive metastatic breast cancer that overexpresses the HER2 receptor for whom hormonal therapy is indicated.
Age Restrictions	
Prescriber Restriction	Approval requires the prescriber to be an Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– TYVASO INHALATION SOLN 0.6MG/ML

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restriction	Restricted to or on consult with Pulmonology or Cardiology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– UCERIS TAB 9MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Patient has active mild to moderate ulcerative colitis and has tried and failed or was intolerant to mesalamine.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– VALCHLOR GEL 0.016% (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Prescribed for the topical treatment of stage IA or IB mycosis fungoides–type cutaneous T-cell lymphoma AND Patient has receive at least TWO (2) prior skin-directed therapies including: topical steroids AND phototherapy (UVB or PUVA).
Age Restrictions	
Prescriber Restriction	Prescribed by Oncology Specialist or Dermatology Specialist or in consultation with a Oncology or Dermatology Specialist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– VASCEPA CAP 1GM

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Patient has triglyceride level greater than or equal to 500 mg/dl.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- VENCLEXTA 10/100/50MG STARTING PACK (New Starts Only)
- VENCLEXTA 10MG TAB (New Starts Only)
- VENCLEXTA 100MG TAB (New Starts Only)
- VENCLEXTA 50MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an Oncologist or Hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– VENTAVIS SOLN 10MCG/ML, 20MCG/ML

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restriction	Restricted to or on consult with Pulmonology or Cardiology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- VFEND IV INJ 200MG
- VFEND SUSP 40MG/ML
- VFEND TAB 50MG, 200MG
- *voriconazole inj 200mg*
- *voriconazole susp 40mg/ml*
- *voriconazole tab 50mg, 200mg*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Infectious Disease Specialist or Oncologist or in consultation with an Infectious Disease Specialist or Oncologist concerning the patient.
Coverage Duration	Approved for six months subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– VOTRIENT TAB 200MG (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Require the prescriber to be an Oncologist or be in under the direct consultation with an Oncologist.
Coverage Duration	Approved for duration of plan year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- VRAYLAR 1.5/3MG MIXED PACK (New Starts Only)
- VRAYLAR 3MG CAP (New Starts Only)
- VRAYLAR 6MG CAP (New Starts Only)
- VRAYLAR 1.5MG CAP (New Starts Only)
- VRAYLAR 4.5MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Trial of two (2) of the following: olanzapine, quetiapine, risperidone, aripiprazole or ziprasidone.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– XALKORI CAP 200MG, 250MG (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or in consult with Oncology Specialist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- XELJANZ 11MG ER TAB
- XELJANZ TAB 5MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Patient has had an inadequate response to, or is intolerant of: etanercept (ENBREL) AND adalimumab (HUMIRA)
Age Restrictions	
Prescriber Restriction	Prescribed by Rheumatology Specialist or in consultation with a Rheumatology Specialist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- *tetrabenazine 12.5mg tab*
- *tetrabenazine 25mg tab*
- XENAZINE TAB 12.5MG, 25MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Patient has chorea due to Huntington's Disease.
Age Restrictions	
Prescriber Restriction	Prescribed by a Neurologist or in consultation with a Neurologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– XGEVA INJ 120MG/1.7ML

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– XOLAIR INJ 150MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	There must be objective evidence of reversible airway obstruction AND the patient's lgE level must be between 30 IU/ml and 700 IU/ml, AND the patient must have a positive skin test or RAST test for specific allergic sensitivity and one of the following: Inadequately controlled asthma despite medium dose of inhaled corticosteroids for at least 3 months in combination with a trial of long-acting inhaled beta-agonists OR a leukotriene modifier and systemic steroids OR high dose inhaled corticosteroids are required to maintain adequate asthma control OR the patient is not adherent to prescribed therapy.
Age Restrictions	Xolair requires the patient to be at least 12 years old.
Prescriber Restriction	Prescriber must be an Allergy or Pulmonary Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– XTANDI CAP 40MG (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or in consult with Oncology Specialist
Coverage Duration	Covered for duration of plan year subject to member eligibility and formulary change.
Other Criteria	

Products Affected

– YERVOY INJ 50MG/10ML (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or in consultation with Oncologist or Dermatologist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Approval based on BvD determination

Products Affected

– ZALTRAP INJ 100MG/4ML (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or in consult with Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– ZELBORAF TAB 240MG (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or in consult with an Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– ZEPATIER 50-100MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	1) Patient is diagnosed with chronic HCV (greater than 6 months) with genotype indicated 2) Current HCV-RNA titer 3) Documentation that member does or does not have cirrhosis 4) Previous Hepatitis C Treatments
Age Restrictions	Member must be 18 years of age or older
Prescriber Restriction	Prescribed by, or in consultation with, a Gastroenterologist, Hepatologist, Infectious Disease or Transplant Specialist
Coverage Duration	Coverage duration of 12 to 16 weeks based on cirrhosis status and previous treatment.
Other Criteria	Treatment regimen will be approved based on genotype and previous treatment experience as defined by current AASLD guidelines.

Products Affected

– ZOLINZA CAP 100MG (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Restricted to or in consult with Oncology or Dermatology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– ZONTIVITY 2.08MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by a Cardiology Specialist or in consultation with an Cardiology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– ZORTRESS TAB 0.25MG, 0.5MG, 0.75MG (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Prescribed for the prophylaxis of organ rejection in adult patients at low-moderate immunologic risk receiving a kidney transplant.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Coverage determination based on Med-B vs. Med-D review.

Products Affected

- VARIVAX INJ
- ZOSTAVAX INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	PA not required for members 50 and older.
Prescriber Restriction	
Coverage Duration	Approved for duration of plan year subject to formulary change and member eligibility
Other Criteria	

Products Affected

– ZYDELIG TAB 100MG, 150MG (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	DIAGNOSIS A: Patient has relapsed CLL, defined as CLL progression less than 24 months since the completion of the last prior therapy AND Idelalisib (ZYDELIG) will be used in combination with rituximab (RITUXAN). DIAGNOSIS B and C: Patient has relapsed follicular B-cell non-Hodgkin lymphoma (FL) OR Patient has relapsed small lymphocytic lymphoma (SLL) AND Patient has received at least two (2) prior systemic therapies.
Age Restrictions	
Prescriber Restriction	Prescribed by or in consultation with an Oncologist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– ZYKADIA CAP 150MG (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Zykadia requires the prescriber to be an Oncologist or under the direct consultation of an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– ZYTIGA TAB 250MG (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or in consult with Oncology Specialist or Urology Specialist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- *linezolid 20 mg/ml susp*
- *linezolid tab 600mg*
- ZYVOX SUSP 100MG/5ML
- *linezolid inj 2mg/ml*
- ZYVOX INJ 2MG/ML
- ZYVOX TAB 600MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Infectious Disease Specialist or in consultation with an Infectious Disease Specialist concerning the patient.
Coverage Duration	Approved for 6 months subject to formulary change and member eligibility.
Other Criteria	